**Bruce S. Dobozin, M.D.**
**Allergy and Asthma**

**YOUR NAME:**______________________________________________

# PATIENT QUESTIONNAIRE

1. This consultation was arranged to evaluate what problem? (List illness or symptom)

   a)_____________________________________________________________

   b)_____________________________________________________________

2. When is the first time the problem occurred?

   a)_____________________________________________________________

   b)_____________________________________________________________

3. Where did the problem occur the first time?

   a)_____________________________________________________________

   b)_____________________________________________________________

4. Describe your first episode.___________________________________________

   _______________________________________________________________

5. Describe a typical episode.____________________________________________

   _______________________________________________________________

6. When did your last episode occur? DATE:_______________________________

7. How often do you have symptoms? Weekly_____ Monthly______ Yearly_____

8. If your problem occurs consistently at certain times of year please indicate the symptom(s) and put an "*X*" under which month(s) it regularly occurs.

   Symptom(s) Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec

   1)__________________________________________________________________________

   2)__________________________________________________________________________

   3)__________________________________________________________________________

9. Or does it occur almost equally all year long? _____ yes _____ no

10. If your problem occurs consistently is it consistently in the:

| | |
|---|---|
| Morning_____________ | Weekdays only ____________ |
| Afternoon____________ | Weekends only ____________ |
| Evening_____________ | Other_____________________ |

11. SELECT all of your symptoms that occur regularly. If you have no problems in that system SELECT:NONE.

1. Eyes: a) itching b) irritation or burning c) redness d) swollen eye lids e) watery discharge f) dryness g) frequent infections h) light sensitivity I) mucous discharge j) NONE

2. Ears: a) popping b) tinnitus (ringing) c) discharge (indicate type: blood__ pus__ colored__ what color:______________) d) frequent infection e) pruritus (itching) f) frequent serous otitis (fluid in ears) g) NONE

3. Nose: a) stuffiness b) itching c) sneezing d) polyps e) frequent colds f) clear discharge g) colored discharge (indicate type: blood___ pus___colored __ what color:_______________) h) purulent discharge i) bloody discharge j) one-sided discharge of any type that is consistent k) NONE

4. Throat, Lips a) itching throat b) swollen lip or tongue c) sore throat d) excess mucous e) post nasal drip f) NONE

5. Sinus: a) pain over forehead b) pain behind eyes c) pain behind bridge of nose d) recurrent sinus infection e) pain in back of the head f) pain on top of head in front g) pain over temples h) NONE

6. Chest: a) wheezing b) cough c) shortness of breath d) tightness in chest e) pain in chest f) spitting up clear mucous g) coughing up mucus plugs (spaghetti shaped mucus) h)spitting up colored mucous (indicate type: Blood___ pus___colored___ what color:______________) i) blood tinged j) blood streaked k) bloody discharge l) purulent discharge m) ever had pneumonia? When__________ n) ever had bronchitis? When___________ o) ever had asthma? When diagnosed?_____________ p) NONE

7. Skin: a) itching b) eczema c) hives d) rash e) blisters f) NONE

8. Bowels: a) nausea b) upset c) diarrhea d) bloating e) cramps f) colic g) NONE

12. Is your illness increasing in frequency or severity?

a) Frequency: _____ yes _____ no b) Severity: ____ yes ____ no

13. Does your illness cause you to:

a) Be ill in the morning when you wake up? _____ yes _____ no
b) Wake up ill during the night? _____ yes _____ no

14. Do you suffer from:

a) Difficulty in going to sleep? _____ yes _____ no
b) Difficulty in waking up? _____ yes _____ no
c) Unusual sleepiness during the waking hours? _____ yes _____ no

15. If you are a woman:

a) Are you pregnant? ___ yes ___ no If yes, at which month of pregnancy? _____
b) Are you planning to become pregnant in the near future?_______ When____________.
c) Are you nursing a baby at this time? ____ yes ____ no
d) Your menarche started when? ________________________.
e) Your menopause started when?_______________________.

16. Have you ever seen an Ear Nose & Throat specialist?___yes ___no If yes when________________

Did this ENT perform surgery? ___yes ___no. If yes, what surgery_____________________________
Did the surgery help your problem? ____yes ____no ____somewhat ____not sure

17. Have you ever seen an Allergist for this problem previously? ___ yes ___ no

If yes: a) What year was the initial visit? ___________ Dr.'s Name: __________________________
b) Over what period of time did you see him/her ____/____ to ____/____
Mo / yr. Mo / yr.

c) What did he/she find you allergic to? (put an "X" next to those that apply)

| | | | | | |
|---|---|---|---|---|---|
| Ragweed | ____ | Dog | ____ | Cockroach | ____ |
| Grass | ____ | Cat | ____ | Latex | ____ |
| Trees | ____ | Weeds | ____ | | |
| Dust | ____ | Foods | ____(List:__________________________________________) | | |
| Mold | ____ | Drugs | ____(List:__________________________________________) | | |
| Mite | ____ | OTHER | ____(List:__________________________________________) | | |

d) Did he/she treat you with immunotherapy (allergy shots): ____yes ____no

If yes: When: from (yr.) _____ to (yr.)_____

What were you treated for?_______________________________________________

e) Did the treatment help you? ____yes ____no ____somewhat ____not sure

f) Why were the allergy shots stopped?________________________________

18. What medication(s) do you **currently take for your allergic** problem?(For inhalers: list # puffs)

(Example: Proventil inhaler: Dose: 2 puffs Frequency:4 times/day)
1)__________________________ Dose (or # puffs): ___________Frequency: ___________/day.
2)__________________________ Dose (or # puffs): ___________Frequency: ___________/day.
3)__________________________ Dose (or # puffs): ___________Frequency: ___________/day.
4)__________________________ Dose (or # puffs): ___________Frequency: ___________/day.

19. What medication(s) have you **taken previously for your allergic problem**?
1)__________________________ Dose (or # puffs): ___________Frequency: ___________/day.
2)__________________________ Dose (or # puffs): ___________Frequency: ___________/day.
3)__________________________ Dose (or # puffs): ___________Frequency: ___________/day.
4)__________________________ Dose (or # puffs): ___________Frequency: ___________/day.

20. What medication(s) do you **currently take for any other reason**? List **all** including non-prescription.
1)__________________________ Dose:___________ Frequency: ___________/day.
2)__________________________ Dose: ___________ Frequency: ___________/day.
3)__________________________ Dose: ___________ Frequency: ___________/day.
4)__________________________ Dose: ___________ Frequency: ___________/day.

21. Were you ever in a hospital? ____ yes ____ no If yes:

a) When?_______________________________________
b) At which hospital______________________________
c) Why were you hospitalized?______________________________________________
d) If asthmatic: How many times have you been to an emergency room for asthma:__________
e) If asthmatic: How many times have you been hospitalized for asthma__________
f) If asthmatic: Have you ever been put on a respirator or into an intensive care unit___yes___no

22. Insect Hypersensitivity: (select any symptoms you have had after a bite or sting)

    a) Stinging Insects: a) swelling b) hives c) shortness of breath d) anaphylaxis e) shock

    b) Non-stinging Insects: Unusual reaction to ____ flies _____mosquitoes.

23. Are you in good health? ____ yes ____ no

24. Do you currently have or did you ever have any of the following:

    ____ Frequent headaches Describe:________________________________
    ____ Glaucoma or Family History of Glaucoma
    ____ Dental Problem Describe:________________________________
    ____ Frequent Swollen Glands
    ____ Hypertension (high blood pressure)
    ____ Heart Disease
    ____ Anemia or other blood disease
    ____ Liver or Kidney Disease
    ____ Thyroid or Endocrine Disease
    ____ Tuberculosis
    ____ Prostate problem
    ____ Diabetes
    ____ Risk for HIV infection or AIDS Describe:__________________________
    ____ Psychiatric or nervous disorder Describe:__________________________
    ____ Addictions or addictive behaviors Describe:__________________________
    ____ Other____________________________________________________

25. Does any food make you ill or produce allergic symptoms?

| Food | Symptom(s) |
|---|---|
| a)____________________ | ______________________ |
| b)____________________ | ______________________ |
| c)____________________ | ______________________ |

26. Did any food make you ill or produce allergic symptoms which you have outgrown?

| Food | Symptom(s) |
|---|---|
| a)____________________ | ______________________ |
| b)____________________ | ______________________ |
| c)____________________ | ______________________ |

27. Does any medication(s) make you ill or produce allergic symptoms?

| Medication | Symptom(s) |
|---|---|
| a)____________________ | ______________________ |
| b)____________________ | ______________________ |
| c)____________________ | ______________________ |

28. Are you or have you ever undergone alternative medical treatments? ___yes ___no If yes, describe:

    a) What type:____________________________________________________
    b) When:________________________________________________________
    c) Where:_______________________________________________________
    d) Outcome:_____________________________________________________

29. Do symptoms occur around (<u>check</u> all that apply):

_____ old leaves
_____ lakeside
_____ summer homes
_____ dry attic
____ hay
____ barns
____ damp basement
____ lawn mowing
____animals
____ rubber (latex) products
____ Other_____________________

30. Are your symptoms produced by or aggravated by (<u>check</u> all that apply):

____ alcohol
____ perfumes
____ insecticides
____ weather changes
____ hair spray
____ hot foods
____ crying
____ cold front
____ auto fumes
____ heat
____ paints
____ air conditioning
____ temperature changes
____ newspapers
____ cold foods
____ emotions
____ air pollution
____ OTHER ______________________________
____ cold
____ cosmetics
____ muggy weather
____ chemicals
____ house dust
____ laughing
____ strong odors
____ bus fumes

31. Do you have pets? ___ yes ___ no If yes:

| Type of pet | How many? | Year acquired? | Year removed? |
|---|---|---|---|
| _______________ | _________ | _____________ | ____________ |
| _______________ | _________ | _____________ | ____________ |
| _______________ | _________ | _____________ | ____________ |

32. Does being near any animal make you worse ___ yes ___ no If yes, which one(s)?

a)__________________________ Indicate Symptom(s):____________________
b)__________________________ Indicate Symptom(s):____________________

33. Has your current house ever been exterminated for cockroaches? ____yes ____no

Have you ever seen a cockroach in your house? ____yes ____no____not since extermination.

34. Have you ***<u>ever</u>*** smoked: ___yes ___ no If yes, what?

_____ cigarettes _____ pipe _____ other:___________________________________

a) How many per day?_______________
b) When did you start?____________(approximate year)
c) When did you stop?____________(approximate year)
d) Have you ever tried to stop___yes ___no How: ___patch___gum___nasal spray___cold turkey___hypnosis___pill___other (describe):______________________________

e) Is there a smoker in your house? ___yes ___no ___sometimes

35. Have you lived for more than one year away from the northeast? ___ yes ___ no If yes:

a) Where?__________________________________________
b) For how long?_____________________________________
c) Did you have your problem while in that area? ___ yes ___ no ____yes, but less severe

36. If you have traveled while you have had your current problem, please list where you traveled, how long, and whether you were better, worse or no change.

a)___________________How long?_____ Better _____Worse _____No Change___
b)___________________How long?_____ Better _____Worse _____No Change___
c)___________________How long?_____ Better _____Worse _____No Change___

37. If the patient is a child less than 17 yr. old answer the following. (If age 17 or above skip this question)

a) Normal growth and development: ____yes ____no (If no, explain: ________________________)

b) Was this child breast fed: ____ yes ____ no (If yes, until what age: ________________________)

c) Vaccines up to date: ____yes ____no (Describe any unusual reactions to vaccines:__________)

d) Behavior problems: ____yes ____no (Describe: ________________________________________)

e) Describe any unusual childhood illnesses:____________________________________________)

g) Frequent infections? ____ yes ____no (If yes, describe: _________________________________)

h) Performance in school: ____Above average ____average ____below average

i) Check number of school days missed in past year because of illness: 0-3 4-7 8-11 12 or more

j) Does the child live with both biological parents? ___yes ___no If no,describe : ________________

_____________________________________________________________________________

38. Select others living with patient: 1) Spouse 2) Significant other 3) Children: number: ____ 4) Mother 5) Father 6) Relative 7) Friend 8) I live alone

The following questions are to gain understanding of your personal history. (If patient is a child, questions apply to the parent completing this form)
Circle & describe sources of stress in your life: 1) Relationship:_____________________________

2) Job:___________________________ 3) Your Health: __________________________________

4) Money: ________________________ 5) Conflicts: _____________________________________

5) Health of others: ______________________________________________________________

Are you happy with your life the way it currently is ____yes ____no ____ somewhat

What changes would you like to make in your life to improve it ? ___________________________

_____________________________________________________________________________

39. **Occupational History**: (to gain understanding of possible allergenic or chemical exposures)
List jobs held for past 15 years by job type (e.g. Sales clerk, nurse, teacher):__________________
_____________________________________________________________________________

Have you ever worked in a health care related job:____ yes ____ no If yes: did you wear latex gloves frequently? Did you or do you sneeze or itch or rash when you put on latex gloves? ____yes ____no

Check any of the following if they are relevant to a current or previous job: beautician, chemicals, cosmetics, dyes, embalming, epoxy or glue, fabric manufacture, fiber glass, insulation, laboratory work, laminating, latex, meat wrapping, metal working, painting, plastics, polyurethane, rubber, textile work, wood working.

40. **Diet history**. Check all that you eat daily or almost daily : fruits, vegetables, milk, cheese, breads, cereal, poultry, red meat, fish, shellfish, candies, chocolate, pastries, juices, beer, wine, liquor.

41. Have you had sneezing, nasal congestion or wheezing when eating (check any that apply) 1) at salad bars 2) dried fruits 3) wine 5) beer 4) sauces or gravies 5) pickles 6) shrimp 7) cider 8) vinegar

42. Have you ever gotten hives (check any that apply): 1) when exercising 2) when showering 3) when exposed to cold air 3) when exposed to sun 4) on the bottom of your feet 5) under a tight belt.

ENVIRONMENTAL EVALUATION

**IF YOU HAVE MORE THAN ONE HOME**, GET A SEPARATE ENVIRONMENTAL EVALUATION FOR EACH

1. Do you work in ____ a. office
____ b. factory
____ c. school
____ d. house
____ e. other ______________________________________________

If a factory, what type?
________________________________________
Is your work place:
____ dusty ____ smoky

a) Is your house in a wooded area? ____ yes ____ no
b) Is there a garden around the house? ____ yes ____ no
c) Are you predominantly in an area with: (CHECK ALL ITEMS THAT APPLY)
____ trees ______ grass ____ weeds
____ urban buildings mainly ____ polluted area

2. Do you live in a(n) ____ a. apartment
____ b. house

How old is the dwelling? (circle one)
1yr 5yr 10yr 20yr or older

Type of neighborhood: ____ a. city
____ b. suburb
____ c. country

3. Is the dwelling ____ a. dry
____ b. damp
____ c. moldy

Do your symptoms become worse after entering a particular room that may be dusty, moldy or cluttered? ___ no ___yes: which room:_____________

4. If you have a basement is it: ____ a. finished ____ c. damp
____ b. unfinished ____ d. dry

5. Do you have an air conditioner? ____ yes ____ no.

6. If yes, is the air conditioner (select one): central or window

7. If central, does it have a(n) ____ a. humidifier on the system
____ b. electronic air cleaner on the system.

c) Does air conditioning make your condition ___ worse ___ better ___ no change
d) When air conditioning is on in your home are you ___ worse ___ better ___ no change

8. Do you have a humidifier in the house? ____ yes ____ no Where?___________________

9. Do you have electronic air cleaners in the house? ____ yes ____ no

10. Is there carpeting in your house? ___ yes ___ no If yes, is it made of any of the following fabrics: wool, synthetic, shag, low pile or other (PLEASE INDICATE)

| Room | Carpet Fabric |
|---|---|
| a)________________________ | ______________________ |
| b)________________________ | ______________________ |
| c)________________________ | ______________________ |
| d)________________________ | ______________________ |

ENVIRONMENTAL EVALUATION -2-

11. What is the carpet padding made of? (felt, foam, synthetic, other-indicate other).

| Room | Padding Fabric |
|---|---|
| a)________________________ | ______________________ |
| b)________________________ | ______________________ |
| c)________________________ | ______________________ |
| d)________________________ | ______________________ |

12. What are your curtains made of? (synthetic, wool, cotton, fiberglass, blend, other). Are they washable? Are they thick or thin?

| Room | Curtain Fabric | Washable? | Thick or Thin? |
|---|---|---|---|
| a)_____________________ | ____________ | __________ | _____________ |
| b)_____________________ | ____________ | __________ | _____________ |
| c)_____________________ | ____________ | __________ | _____________ |
| d)_____________________ | ____________ | __________ | _____________ |

13. Do you have plants in the house? ___ yes ___ no If yes,

a) How many? _______________

b) Are they moldy? ___ yes ___ no If yes, which rooms are they situated in?___________________

14. What type of heating system do you have?___________________________________

15. When you leave your house do your symptoms: ___ increase ___ decrease ___ do not change

**BEDROOM**

16. Is there air conditioning in the bedroom? ___ yes ____ no If yes, (circle one) central or window

17. If central, does the air conditioning have:

a) a humidifier system? ___ yes ___ no

b) an electronic air cleaning system? ___ yes ___ no

18. What type of bedding do you use? a) pillows: ___down ___foam ___ Dacron ___other:_____________

Do the pillows have a special allergy proof cover? ___ yes ___ no

b) Blankets: ___down ___synthetic ___wool ___other:__________________
c) Comforters: ___down ___synthetic ___other____________________________

19. What is your mattress made of? ___horsehair ___synthetic ___ latex ___cotton ___other:__________

Does it have a special allergy proof cover? ___yes ___no

20. What is your box spring made of? ___horsehair ___synthetic ___latex ___cotton ___other:_________

Does it have a special allergy proof cover? ___yes ___no

21. Are there plants in the bedroom? ___yes ___not If yes, a) How many?_________

b) Are they moldy? ___yes ___no Where located?______________________________________

22. Is there carpeting in your bedroom? ___yes ___no

If yes, is the carpet made of: ___wool ___synthetic ___fiber (which fiber):_________________

___shag ___low-pile ___flat ___other:___________________

ENVIRONMENTAL EVALUATION -3-

23. If there is bedroom carpet, what is the padding under the carpet made of:
____felt ____latex ____other:____________________________________________________

24. Is the bedroom furniture upholstered? ___yes ___no If yes, with what?_______________________

25. Are your closets: ___full ___empty ___dusty ___camphoric ___ other:____________________

26. Are there any leaks in the bedroom? ___yes ___no

27. Is the bedroom damp? ___yes ___no

28. Is the bedroom moldy? ___yes ___ no

29. Do you have wallpaper? ___yes ___no If yes, answer the following:

a) How old?_______

b) Is there any mold resistant material in the wall paper? ____yes ___no

c) Is the wallpaper moldy? ___yes ___no

30. Are there curtains or drapes?___ yes ___no (Indicate which)_________________

a) Are they: ____washable ____non-washable
b) Are they made of: ___cotton ____wool ____synthetic ___other:______________________

31. Are there Venetian blinds on the window(s) ___ yes ___no

32. If you have a bedroom window is it in the close proximity to any potential allergen(s) (e.g., trees or an exhaust vent)? ___yes ____no If yes, please indicate which allergen(s):______________________

33. How many air vents open into your bedroom from the heating or the air conditioning?_____________

34. a) When the heating goes on do your symptoms get: ___worse ___better ___ no change

b) When the air conditioning goes on do your symptoms get: ___worse ___ better ___ no change

35. Is there any room in the house where you are worse (or where there is no change)? ____yes ____ no
If yes, please indicate which room(s)__________________________________

36. Is there a room in the house where you are better? ____yes ____no Which room(s)_____________

**OFFICE OR WORK PLACE**

37. Is there an air conditioner at work? ____yes ____no If yes, (circle one) central or window

38. If central, does it have: a) a humidifier on the system? ___yes ___no
b) an electronic air cleaner on the system? ___yes ___no
c) Does the air conditioning at work make your condition: ___worse ____better ___no change
d) When air conditioning goes on in your home are you: ___worse ____better ___no change

39. Are there air purifiers or humidifiers in your work place? ___yes ___no
If yes, indicate which ___________________________________________________

40. Is there carpeting in your work place? ___yes ___no If yes, answer the following:

a) Is it made of: ___wool ___synthetic ___fiber (indicate type)_______________________
___shag ___low-pile ___other:__________________________________

b) What is the padding made of: ___felt ____foam ____synthetic ___other:______________

41. Do you work in a sealed building (windows are not opened for ventilation)? ____yes ____no.

42. Does anyone in your workplace have similar symptoms to you? ____yes ____no.

ENVIRONMENTAL EVALUATION -4-

43. Are you exposed to industrial products such as Xerox materials, cleaning chemicals, fumes, etc.?
____yes ____no If yes, what type?______________________________________

44. Are you exposed to various fabrics, dyes, formaldehyde, or industrial toxins?
____yes ____no If yes, what type?______________________________________

45. When the heat is on in your workplace are you: ___worse ___better ___no change

46. Are your worse, better, or is there no significant change when you are in your workplace ?
____worse ____better ____no change Are you better on weekends? ____yes ____no

**PERTINENT PAST HISTORY** DATE PLACE RESULTS

LAST CHEST X-RAY______________________________________________________________
LAST SINUS X-RAY______________________________________________________________
LAST SINUS CAT SCAN or MRI_____________________________________________________
LAST PULMONARY FUNCTION TEST__________________________________________________
ORAL CORTISONE PRESCRIPTIONS__________________________________________________

**FAMILY HISTORY OF ALLERGY** – "X" appropriate column for each relative who has/had that illness.

| | Asthma | Nasal Allergy | Eczema | Hives | Drug Allergy | Food Allergy |
|---|---|---|---|---|---|---|
| **Mother** | | | | | | |
| **Father** | | | | | | |
| **Sisters** | | | | | | |
| **Brothers** | | | | | | |
| **Mother's Sisters** | | | | | | |
| **Mother's Brothers** | | | | | | |
| **Father's Sisters** | | | | | | |
| **Father's Brothers** | | | | | | |
| **Mother's Parents** | | | | | | |
| **Father's Parents** | | | | | | |
| **Your Children** | | | | | | |

How many children do you have:_______ List birth year of each child: __________________________

ANY ADDITIONAL COMMENTS YOU WOULD LIKE TO MAKE ?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________